DELTA DENTAL®

Delta Dental Plan of California

For

Employees

Of

Group No. 3712

Combined Evidence of Coverage and Disclosure Form

USING THIS BOOKLET

This booklet has been written with you in mind. It is designed to help you make the most of your Delta dental plan. This combined Evidence of Coverage/Disclosure form discloses the terms and conditions of your coverage.

The Combined Evidence of Coverage/Disclosure form should be read completely and carefully and individuals with special health care needs should read carefully those sections that apply to them (see CHOOSING YOUR DENTIST section). You have a right to review it prior to your enrollment.

Please read the "DEFINITIONS" section. It will explain to you any words that have special or technical meanings under your group Contract. A copy of the Contract will be furnished upon request.

Please read this summary of your dental Benefits carefully. Keep in mind that YOU means the ENROLLEES whom Delta covers. WE, US and OUR always refers to Delta Dental Plan of California (Delta).

If you have any questions about your coverage that are not answered here, please check with your personnel office, or with Delta.

DELTA DENTAL PLAN OF CALIFORNIA

P.O. Box 997330
Sacramento, California 95899-7330

For claims, eligibility and benefits inquiries, or additional information, call Delta's Customer and Member Service department toll-free at:
1-800-765-6003.

Or contact us on the Internet at:

e-mail: cms@delta.org
web site: www.deltadentalca.org

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

This Combined Evidence of Coverage/Disclosure Form constitutes only a summary of the dental plan. The dental Contract must be consulted to determine the exact terms and conditions of coverage.

TABLE OF CONTENTS

DEFINITIONS

Certain words that you will see in this booklet have specific meanings. These definitions should make your dental plan easier to understand.

Attending Dentist's Statement - a form used by your dentist to request payment for dental treatment or predetermination for proposed dental treatment.

Benefits - those dental services available under the Contract and which are described in this booklet.

Contract - the written agreement between your employer or sponsoring group and Delta to provide dental Benefits. The Contract, together with this booklet, forms the terms and conditions of the Benefits you are provided.

Covered Services - those dental services to which Delta will apply Benefit payments, according to the Contract.

Deductible - the amount you must pay for dental care each Plan Year before Delta's Benefits begin.

Delta Dentist - a Dentist who has signed an agreement with Delta or a Participating Plan, agreeing to provide services under the terms and conditions established by Delta or the Participating Plan.

DeltaPreferred Option Dentist - a Delta Dentist who meets the criteria for the DeltaPreferred Option plan and has made a special agreement with Delta to participate in this plan, or a Delta Dentist who specializes in oral surgery, endodontia and periodontia.

Dependent - a Primary Enrollee's Dependent who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Effective Date - the date this plan starts.

Enrollee - A Primary Enrollee or Dependent enrolled to receive Benefits or a person who chooses to pay for OPTIONAL CONTINUATION OF COVERAGE.

Maximum - the greatest dollar amount Delta will pay for covered procedures in any contract year or lifetime for Orthodontic Benefits.

Participating Plan – Delta and any other member of the Delta Dental Plans Association with whom Delta contracts for assistance in administering your Benefits.

Plan Year - December 1 through November 30 for active employees; February 1 through January 31 for retirees. A Plan Year shall be each 12 month period thereafter.

Premiums - the money paid each month for you and your Dependents' dental coverage.

Primary Enrollee - any group member or employee who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

Single Procedure – a dental procedure to which a separate Procedure Number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

Usual, Customary and Reasonable (UCR) -

A Usual fee is the amount which an individual dentist regularly charges and receives for a given service or the fee actually charged, whichever is less.

A Customary fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area.

A Reasonable fee schedule is reasonable if it is Usual and Customary. Additionally, a specific fee to a specific patient is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

WHO IS COVERED?

All permanent full-time employees are eligible to enroll. If you are hired as a full-time employee on the 1st through the 4th of a particular month, you will become eligible to receive Benefits on the first day of the following month. If you are hired on the 5th or later of a particular month, you will become eligible to receive Benefits on the first day of the month coincident with or next following one month of continuous, full-time employment.

Retirees are also eligible to continue coverage in this plan.

If you are away from work on the date your coverage would normally start, it will not become effective until you return to work.

You are not eligible if you are not reporting to work on a regular basis and are not actively employed. Coverage resumes on the first day of the month after you return to active employment, report to work regularly and amounts due to Delta for coverage have been paid. But, coverage can continue without interruption if your employer continues to report you as a Primary Enrollee and amounts due Delta for your coverage continue to be paid.

Family and Medical Leave Act of 1993

You can continue your coverage if you take a leave governed by the Family and Medical Leave Act of 1993. If you do not continue your coverage during the governed leave, it will be reinstated at the same Benefit level you received before your leave.

Uniformed Services Employment and Re-employment Rights Act of 1994

You can continue coverage for up to 18 months, if you take a leave governed by the Uniformed Services Employment and Re-employment Rights Act of 1994. If you make this election, you must submit any Premiums necessary, which may include administrative costs, to your employer. If you do not continue your coverage during a military leave, it will be reinstated at the same Benefit level you received before your leave.

WHO ARE YOUR ELIGIBLE DEPENDENTS?

- Your legal spouse or domestic partner;
- Your unmarried dependent children until their 19th birthday;
- Your unmarried dependent children until their 26th birthday if enrolled full-time in an accredited school, college or university;
- An unmarried dependent child aged 19 or older who is incapable of self-support because of a physical or mental handicap that occurred before he or she turned 19, if the child is mostly dependent on you for support. Proof of this handicap must be given to Delta or your employer within 31 days, if it is requested. Proof will not be required more than once a year after the child has reached age 21.

"Dependent children" also means stepchildren, adopted children, children placed for adoption and foster children in a certified foster home, provided that they are dependent upon you for support and maintenance.

A domestic partnership shall exist between two people (of the same gender only) and each of them shall be the domestic partner of the other if they both complete, sign and file with the employee's Human Resources Department an Affidavit of Domestic Partnership. A domestic partner is subject to the same terms and conditions as any other Dependent enrolled under this Contract. The Dependents of a domestic partner are not eligible for coverage in this plan.

A surviving Dependent of a deceased Primary Enrollee may be able to continue coverage under this plan. Please check with your Human Resources department.

Dependent coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO).

No Dependent in the military service is eligible.

ENROLLING YOUR DEPENDENTS

Your Dependents must be enrolled when you first become eligible or on the first day of the month after they become Dependents.

Employees must complete change forms to add new Dependents.

WHEN YOU ARE NO LONGER COVERED

1. If you stop working for your employer, your dental coverage will end on the last day of the month in which you stop working, unless you qualify for and pay for OPTIONAL CONTINUATION OF COVERAGE. Your Dependents' coverage ends when yours does, or as soon as they are no longer Dependents, unless they choose to pay for OPTIONAL CONTINUATION OF COVERAGE.
2. When the Contract between Delta and your employer is discontinued or canceled, your coverage ends immediately.

CANCELING THIS PLAN

Delta may cancel this plan only on an anniversary date (period after the plan first takes effect or at the end of each renewal period thereafter), or any time if payments required by the Contract are not made to Delta.

If you believe that this plan has been terminated or not renewed due to your health status or requirements for health care services (or that of your Dependents), you may request a review by the California Director of the Department of Managed Health Care.

If the Contract is terminated for any cause, Delta is not required to predetermine services beyond the termination date or to pay for services provided after the termination date, except for Single

Procedures begun while the Contract was in effect which are otherwise Benefits under the Contract.

If this plan is canceled, you and your Dependents have no right to renewal or reinstatement of your Benefits.

YOUR BENEFITS

Your dental plan covers several categories of Benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

After you have satisfied any Deductible requirements, Delta will provide payment for these services at the percentage indicated, up to a Maximum of:

$2,000 for each Enrollee in each Plan Year for services provided by a DeltaPreferred Option Dentist; and

$1,000 for each Enrollee in each Plan Year for services provided by any other dentist.

Payment for Orthodontic Benefits is limited to a lifetime Maximum of $2,000 for each eligible dependent child and $1,000 for each eligible adult.

An agreement between your employer and Delta is required to change Benefits during the term of the Contract.

The following Benefits are limited to the applicable percentages of dentist's fees or allowances specified below. You are required to pay the balance of any such fee or allowance, known as the "patient copayment." If the dentist discounts, waives or rebates any portion of the patient copayment to the Enrollee, Delta only provides as Benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

I. DIAGNOSTIC AND PREVENTIVE BENEFITS

100% if provided by a DeltaPreferred Option Dentist
100% if provided by other dentists

Diagnostic - oral examinations; x-rays; diagnostic casts; examination of biopsied tissue; palliative (emergency) treatment of dental pain; specialist consultation

Preventive - prophylaxis (cleaning); fluoride treatment; space maintainers

II. BASIC BENEFITS

80% if provided by a DeltaPreferred Option Dentist
80% if provided by other dentists

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care

Restorative - amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic - treatment of the tooth pulp

Periodontic - treatment of gums and bones that support the teeth

Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services - general anesthesia; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment

II. CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

80% if provided by a DeltaPreferred Option Dentist
80% if provided by other dentists

Crowns, Jackets, Inlays, Onlays and Cast Restorations are Benefits only if they are provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations.

IV. PROSTHODONTIC BENEFITS

80% if provided by a DeltaPreferred Option Dentist
80% if provided by other dentists

Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth.

V. ORTHODONTIC BENEFITS – 50%

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

VI. DENTAL ACCIDENT BENEFITS – 100%

Any services which would be covered under other Benefit categories (subject to the same limitations and exclusions) are covered instead by your dental accident coverage when they are provided for conditions caused directly by external, violent and accidental means.

LIMITATIONS

1. An oral examination is a Benefit only twice in any calendar year while you are eligible under any Delta program. Oral examinations provided by a California dentist are Benefits only when the dentist is a Delta Dentist with an accepted fee on file with Delta.

2. Full-mouth x-rays are a Benefit once in a three-year period while you are eligible under any Delta plan.

3. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year, while you are eligible under any Delta plan.

4. Only the first two cleanings, fluoride treatments, or Single Procedures which include cleaning, or combination thereof, in a calendar year are Benefits while you are eligible under any Delta plan.

5. Sealant Benefits are limited to eligible dependent children under age 14. Sealant Benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations and with the occlusal surface intact. Sealant Benefits do not include the repair or replacement of a sealant on a tooth within three years of its application.

6. Crowns, Jackets, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are eligible under any Delta plan, unless Delta determines that replacement is required

because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

7. Prosthodontic appliances are Benefits only once every five years, while you are eligible under any Delta plan, unless Delta determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta plan will be made if it is unsatisfactory and cannot be made satisfactory.

8. Delta will pay its percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Delta's Dentists. A standard partial or complete denture is one made from accepted materials and by conventional methods. The maximum fee allowance is revised periodically, as dental fees change. If your dentist's accepted fee on file with Delta for a partial or complete denture is higher than this maximum allowance, you must pay that portion of his or her fee that exceeds Delta's allowance in addition to your portion of the allowance.

9. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your plan. However, if implants are provided along with a covered prosthodontic appliance, Delta will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta makes such an allowance, we will not pay for any replacement for five years following the completion of the service.

10. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee.

    For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

11. If orthodontic treatment is begun before you become eligible for coverage, Delta's payments will begin with the first payment due to the dentist following your eligibility date.

12. Delta's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

13. Delta will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the Enrollee selects specialized orthodontic appliances or procedures chosen for aesthetic considerations an allowance will be made for the cost of a standard orthodontic treatment plan and the patient is responsible for the remainder of the Dentist's fee.

14. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

15. Delta will pay Dental Accident Benefits when services are provided within 180 days following the date of accident and shall not include any services for conditions caused by an accident occurring before your eligibility date.

EXCLUSIONS/SERVICES WE DO NOT COVER

Delta covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is important for you to know what these services are before you visit your dentist.

Delta does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws.

2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

3. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

5. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this plan.

6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

7. Experimental procedures.

8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

11. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants, except as provided under LIMITATIONS.

12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

13. Replacement of existing restoration for any purpose other than active tooth decay.

14. Intravenous sedation, occlusal guards and complete occlusal adjustment.

15. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.

DEDUCTIBLES

If services are received from a DeltaPreferred Option Dentist:

There are no Deductible requirements.

If services are received from any other dentist:

You must pay the first $50 of Covered Services for each Enrollee in your family in each Plan Year, except for Diagnostic and Preventive Benefits and Dental Accident Benefits, up to a limit of $150 per family.

COVERED FEES

It is to your advantage to select a dentist who is a Delta Dentist, since a lower percentage of the dentist's fees may be covered by this plan if you select a dentist who is not a Delta Dentist.

A list of Delta Dentists (see DEFINITIONS) is available in a directory at your group benefits office, or by calling 1-800-427-3237.

Payment to a DeltaPreferred Option Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, the dentist's accepted Usual, Customary and Reasonable Fee on file with Delta, or a fee which the dentist has contractually agreed upon with Delta to accept for treating enrollees under this plan.

Payment to a Delta Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the accepted fee that the dentist has on file with Delta.

Payment for services by a California dentist, or an out-of-state dentist, who is not a Delta Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee which satisfies the majority of Delta Dentists.

Payment for services by a dentist located outside the United States will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee which satisfies the majority of Delta dentists.

CHOOSING YOUR DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Nearly 22,300 dentists in active practice in California are Delta Dentists. About 10,600 of these Delta Dentists are also DeltaPreferred Option Dentists. You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dentist. This is because his or her fees are approved in advance by Delta. Delta Dentists have treatment forms on hand and will complete and submit the forms to Delta free of charge.

If you choose a DeltaPreferred Option Dentist, you will receive all of the advantages of going to a Delta Dentist, and you may have a higher level of Benefits for certain services.

If you go to a non-Delta Dentist, Delta cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dentists may be submitted to Delta at the address listed on page 1.

Dentists located outside the United States are not Delta Dentists. Claims submitted by out-of-country dentists are translated by Delta staff and the currency is converted to U.S. dollars. Claims submitted by out-of-country dentists for patients residing in California are referred to Delta's Quality Review department for processing. Delta may require a clinical examination to determine the quality of the services provided, and Delta may decline to reimburse you for Benefits if the services are found to be unsatisfactory.

A list of DeltaPreferred Option Dentists and Delta Dentists can be obtained by calling 1-800-427-3237. This list will identify those dentists who can provide care for individuals who have mobility impairments or have special health care needs. You can obtain specific information about DeltaPreferred Option Dentists and Delta Dentists by using our web site – www.deltadentalca.org or calling the Delta Customer and Member Service department at the number shown on page 1. A printed list of the DeltaPreferred Option Dentists and Delta Dentists in your area is also available by calling 1-800-427-3237.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society that is listed in the local telephone directory.

Services from dental school clinics may be provided by students of dentistry or instructors who are not licensed by the state of California.

Delta shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta cannot ensure your dentist's use of precautions against the spread of such diseases, or compel your dentist to be tested for HIV or to disclose test results to Delta, or to you. Delta informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this issue. If you should have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

CONTINUITY OF CARE

If you are undergoing a course of treatment and your dentist no longer is a DeltaPreferred Option Dentist or Delta Dentist, you may continue to receive treatment from that dentist.

PUBLIC POLICY PARTICIPATION BY ENROLLEES

Delta's Board of Directors includes Enrollees who participate in establishing Delta's public policy regarding Enrollees through periodic review of Delta's Quality Assessment program reports and communications from Enrollees. Enrollees may submit any suggestions regarding Delta's public policy in writing to: Delta Dental Plan of California, Customer and Member Service Department, P.O. Box 997330, Sacramento, CA 95899-7330.

SAVING MONEY ON YOUR DENTAL BILLS

You can keep your dental expenses down by practicing the following:

1. Compare the fees of different dentists;

2. Use a Delta Dentist;

3. Have your dentist obtain predetermination from Delta for any treatment over $300;

4. Visit your dentist regularly for checkups;

5. Follow your dentist's advice about regular brushing and flossing;

6. Avoid putting off treatment until you have a major problem; and

7. Learn the facts about overbilling. Under this plan, you must pay the dentist your copayment share (see YOUR BENEFITS). You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your plan and may do more work than you need, thereby increasing plan costs. You can help keep your dental Benefits intact by avoiding such schemes.

8. Although the levels (i.e. percentages) of Benefits are the same no matter what dentist you choose, your out-of-pocket expenses may differ depending upon whether you select a DeltaPreferred Option Dentist. When receiving treatment from a non-DeltaPreferred Option Dentist, you will be responsible for a Deductible and have potentially greater out-of-pocket expenses. Delta's payment to a dentist who is a non-DeltaPreferred Option Dentist will be based upon the applicable percentage of the lesser of the fee actually charged or the pre-negotiated DeltaPreferred Option Dentist fee. However, your share of the costs may be greater because if the non-DeltaPreferred Option Dentist charges you a fee that is higher than the pre-negotiated DeltaPreferred Option Dentist fee, you will be responsible for the difference.

YOUR FIRST APPOINTMENT

During your first appointment, be sure to give your dentist the following information.

1. Your Delta group number: 3712

2. The employer's name: City of Long Beach

3. Primary Enrollee's social security number (which must also be used by Dependents)

4. Primary Enrollee's date of birth

5. Any other dental coverage you may have

PREDETERMINATIONS

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta will pay if you are eligible and meet all the requirements of your plan at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send an Attending Dentist's Statement to us listing the proposed treatment. Delta will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual Maximum when completed services are submitted to Delta.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

PAYMENT

Delta will pay Delta Dentists directly. Delta Dental Plan of California's agreement with our Delta Dentists makes sure that you will not be responsible to the dentist for any money we owe. However, if for any reason we fail to pay a dentist who is not a Delta Dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dentist, Delta will pay you. Payments made to you are not assignable (in other words, we will not grant requests to pay non-Delta Dentists directly).

Payment for claims exceeding $500 for services provided by dentists located outside the United States may, at Delta's option, be conditioned upon a clinical evaluation at Delta's request (see Second Opinions). Delta will not pay Benefits for such services if they are found to be unsatisfactory.

Delta does not pay Delta Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service. If you wish to know more about the method of reimbursement to Delta Dentists, you may call Delta's Customer and Member Service department for more information.

Payment for any Single Procedure which is a Covered Service will only be made upon completion of that procedure. Delta does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any Deductible (and determines when a charge is made against any Maximum) under your plan.

If there is a difference between what your dentist is charging you and what Delta says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta's Customer and Member Service department. We may be able to help you resolve the situation.

Delta may deny payment of any Attending Dentist's Statement for services submitted more than 12 months after the date the services were provided. If a claim is denied due to a Delta Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta (unless you failed to advise the dentist of your eligibility at the time of treatment).

The process Delta uses to determine or deny payment for services is distributed to all Delta Dentists. It describes in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the plan. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Delta's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta's Customer and Member Service department for more information regarding Delta's processing policies.

IF YOU HAVE QUESTIONS ABOUT SERVICES FROM A DELTA DENTIST

If you have questions about the services you receive from a Delta Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Review department at 1-800-765-6003. If appropriate, Delta can arrange for you to be examined by one of our consulting dentists in your area. If the consultant recommends the work be replaced or corrected, Delta will intervene with the original dentist to either have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full Benefit.

SECOND OPINIONS

Delta obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta to perform the clinical examination. When Delta authorizes a second opinion through a Regional Consultant, we will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination may be submitted to Delta for payment. Delta will pay such claims in accordance with the Benefits of the plan.

This is only a summary of Delta's policy on second opinions. A copy of Delta's formal policy is available from Delta's Customer and Member Service department upon request.

ORGAN AND TISSUE DONATION

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

GRIEVANCE PROCEDURE AND CLAIMS APPEAL

If you have any questions about the services received from a Delta Dentist, we recommend that you first discuss the matter with your Dentist. If you continue to have concerns, you may call or write us.

We will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between you and your group. If you have any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta, or the quality of dental services performed by a Delta Dentist, you may call us toll-free at 1-800-765-6003, contact us on the Internet through e-mail: cms@delta.org or through the web site: www.deltadentalca.org or write us at P.O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer and Member Service Department.

If your claim has been denied or modified, you may file a request for review (a grievance) with us within 180 days after receipt of the denial or modification. If in writing, the correspondence must include your group name and number, the Primary Enrollee's name and social security number, the inquirer's telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Our review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of our regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Our review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and we will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract terms, we shall consult with a dentist who

has appropriate training and experience. The identity of such dental consultant is available upon request.

We will provide the Enrollee a written acknowledgement within five days of receipt of the request for review. We will make a written decision within 30 days of receipt, or inform the Enrollee of the pending status if more information or time is needed to resolve the matter. We will respond, within three days of receipt, to complaints involving severe pain and imminent and serious threat to a patient's health. You may file a complaint with the Department of Managed Health Care after you have completed Delta's grievance procedure or after you have been involved in Delta's grievance procedure for 30 days. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your plan at **1-800-765-6003** and use your plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR)*. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

* IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Pension and Welfare Benefits Administration for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Pension and Welfare Benefits Administration 200 Constitution Avenue, N.W. Washington, D.C. 20210.

IF YOU HAVE ADDITIONAL COVERAGE

It is to your advantage to let your dentist and Delta know if you have dental coverage in addition to this Delta plan. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both plans - sometimes paying 100% of your dental bill. For example, you might have some fillings that cost $100. If the primary carrier usually pays 80% for these services, it would pay $80. The secondary carrier might usually pay 50% for this service. In this case, since payment is not to exceed the entire fee charged, the secondary carrier pays the remaining $20 only. Since this method pays 100% of the bill, you have no out-of-pocket expense.

Be sure to advise your dentist of all plans under which you have dental coverage and have him or her complete the dual coverage portion of the Attending Dentist's Statement, so that you will receive all benefits to which you are entitled. For further information, contact the Delta Customer and Member Service department at the number in the USING THIS BOOKLET section.

OPTIONAL CONTINUATION OF COVERAGE

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to employers with two to 19 employees), both require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, *at your expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event and whether you are covered under federal COBRA or Cal-COBRA.

DEFINITIONS

The meaning of key terms used in this section are shown below and apply to both federal and Cal-COBRA.

Qualified Beneficiary means:

1. You and/or your Dependents who are enrolled in the Delta plan on the day before the Qualifying Event, or

2. A child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1. The termination of employment (other than termination for gross misconduct) or the reduction in work hours, by your employer;

Event 2. Your death;

Event 3. Your divorce or legal separation from your spouse;

Event 4. Your Dependents' loss of dependent status under the plan, and

Event 5. As to your Dependents only, your entitlement to Medicare.

You means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18 month period can be extended for a total of 29 months, provided:

1. A determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and

2. Notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your employer or Delta within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your Dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your Dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's Dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

PERIODS OF CONTINUED COVERAGE UNDER CAL-COBRA (groups of 2 - 19)

In the case of Cal-COBRA, Delta will act as the administrator. Notification and premium payments should be made directly to Delta. Notifications and payments should be delivered by first-class mail, certified mail, or other reliable means of delivery.

Individuals who are eligible for coverage under the federal COBRA law are not eligible for coverage under Cal-COBRA. The employer must notify Delta in writing within 30 days of the date when the employer becomes subject to COBRA.

Qualified Beneficiaries may continue coverage for 36 months following the month in which Qualifying Events 1, 2, 3, 4 or 5 occur.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continuation coverage; and notice of the determination is given to the employer during the initial period of continuation coverage and within 60 days of the date of the social security determination letter, the Qualified Beneficiary may continue coverage for a total of 36 months following the month in which Qualifying Event 1 occurs.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Qualified Beneficiary must notify the employer, or administrator within 30 days of any such determination.

If, during the 36-month continuation period resulting from Qualifying Event 1, the Qualified Beneficiary experiences Qualifying Events 2, 3, 4 or 5, he or she must notify the employer within 60 days of the second qualifying event and has a total of 36 months continuation coverage after the date of the date of the first Qualifying Event.

Delta shall notify the Primary Enrollee of the date his or her continued coverage will terminate. This termination notification will be sent during the 180 day period prior to the end of coverage.

ELECTION OF CONTINUED COVERAGE

A Qualified Beneficiary will have 60 days from a Qualifying Event to give Delta written notice of the election to continue coverage.

Upon receipt of the written notice, Delta will provide a Qualified Beneficiary with the necessary benefits information, monthly Premium charge, enrollment forms, and instructions to allow election of continued coverage. Failure to provide this written notice of election to Delta within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial Premiums to Delta, which includes the Premiums for each month since the loss of coverage. Failure to pay the required Premiums within the 45 days will result in the loss of the right to continue coverage, any Premiums received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their Dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occurs:

1. The allowable number of consecutive months of continued coverage is reached;
2. Failure to pay the required Premiums in a timely manner;
3. The employer ceases to provide any group dental plan to its employees;
4. The individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or Dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
5. Entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary either 30 days prior to the termination or when all Enrollees are notified, whichever is later, of the ability to elect continuation of coverage under the employer's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Delta plan had such plan with the former employer not terminated. The employer shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of Premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Delta plan.